

Audit



Report

OFFICE OF THE INSPECTOR GENERAL

PRIME VENDOR SUPPORT OF MEDICAL SUPPLIES

Report No. 96-109

May 7, 1996

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Department of Defense

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Acronyms

DPSC	Defense Personnel Support Center
DAPA	Distribution and Pricing Agreement
MEDCAT-X	Expanded Medical Catalog
MTF	Medical Treatment Facility
PPC	Product and Price Comparison



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MEMORANDUM FOR DIRECTOR, DEFENSE LOGISTICS AGENCY

**SUBJECT: Audit of Prime Vendor Support of Medical Supplies
(Project No. 5LD-0037)**

Introduction

We are providing this report for your information and use. The Prime Vendor Program for medical supplies uses commercial business practices to support the needs of medical treatment facilities (MTFs). During FY 1995, MTFs purchased \$476 million of medical, surgical, and pharmaceutical items from prime vendors.

Audit Results

The Directorate of Medical Materiel, Defense Personnel Support Center (DPSC), a subordinate Defense Logistics Agency organization; the Surgeons General of the Army, the Navy, and the Air Force; and participating MTFs have successfully implemented a Prime Vendor Program that mirrors the commercial business practices for the purchase of medical supplies.

We identified errors in the automated programs used by MTFs, errors in valuation of prime vendor transactions, and errors in one prime vendor methodology used to determine the costs of materials. We also noted that MTFs were not taking full advantage of manufacturer rebate programs. Those errors were not significant and were generally corrected during the audit. See Enclosure 1 for a discussion of the benefits of the Prime Vendor Program that were achieved and Enclosure 2 for a summary of the errors identified, and corrective actions taken by management.

Audit Objectives

Our objectives were to review the effectiveness of the Prime Vendor Program used for the procurement of medical supplies, including a review of the overall program benefits and compliance with program guidance. The audit also included a review of management controls as they applied to our objectives.

Scope and Methodology

Scope. We reviewed DPSC policy and procedures related to the Prime Vendor Program. We identified 243 MTFs that participated in the Prime Vendor Program as of June 1995. MTFs included military hospitals, medical and dental clinics, logistics supply organizations, and non-DoD Governmental

organizations. Purchases of medical supplies through the Prime Vendor Program were very limited for other than DoD organizations. Purchases for the 243 MTFs totaled \$166 million from March through June 1995. We also reviewed wholesale inventory records of the Directorate of Medical Materiel from January 1992 through September 1995 and billing records from January 1993 through September 1995.

We reviewed Directorate of Medical Materiel distribution and pricing agreements (DAPAs), obligation and billing records, and prime vendor transactions for 48 invoices (issued from March through June 1995) at the 12 MTFs we visited. We also reviewed prime vendor documents (including receiving reports and vendor invoices) that related to those 48 invoices.

Limitations to Audit Scope. We limited our audit work to 12 MTFs in the continental United States with total purchases in excess of \$250,000 from March through June 1995. Purchases for those 12 facilities totaled \$26.9 million during that period.

Computer-Processed Data. We analyzed the data available from computer reports, records, and statistics (from FY 1993 through FY 1995) that the Directorate of Medical Materiel used to manage the prime vendor program. Additionally, we analyzed the data available in two independent automated supply management programs, the Product and Price Comparison (PPC) and the expanded Medical Catalog (MEDCAT-X). Except for our tests of pricing and our review of the automated supply management programs identified above, we did not independently determine the reliability of the computer-processed data. However, not evaluating the reliability of the computer-processed data did not materially affect the results of our review.

Audit Period, Standards, and Location. We performed this economy and efficiency audit from April through December 1995 in accordance with auditing standards issued by the Comptroller General of the United States, as implemented by the Inspector General, DoD. Enclosure 4 lists the organizations visited or contacted.

Site Selection Methodology. We judgmentally selected 12 MTFs (four each from the Army, the Navy, and the Air Force). We grouped the 243 MTFs into six groups by prime vendor (some prime vendors were awarded contracts for more than one geographical region) and judgmentally selected two MTFs from each of the prime vendor groups so that the selection included four facilities from each Military Department. We combined the regions of two prime vendors, Amerisource Corporation and Dakota Drug, into a single group because only five MTFs were in those regions.

Sample Selection Methodology. We judgmentally selected for review four pharmaceutical invoices (or a combination of medical and surgical and pharmaceutical invoices) that were billed to each of the 12 MTFs from March through June 1995 to determine whether prime vendors charged correct prices to MTFs. The 48 invoices selected had 4,118 individual items with a total purchase value of \$1.4 million.

We limited the sample selection time period to March through June 1995 because personnel in the Directorate of Medical Materiel stated that a new methodology for approving price changes was implemented in early February 1995. A review of invoices before March 1995 would have included differences that were attributable to that process change.

Customer Survey. We developed a customer survey that addressed the medical Prime Vendor Program and sent the questionnaire to 294 requisitioners (excluding Navy ships and overseas facilities) that were identified in prime vendor awards. We received 116 responses and used the responses in our assessment of the Prime Vendor Program.

Manufacturer Rebates. We conducted a limited review of manufacturer rebate programs and reviewed a Tri-Service process action team review of existing rebate programs. We attempted to identify those organizations that received manufacturer rebates and how materiel received from the rebates was accounted for in MTF accountable records. In addition, we compared the results that the Tri-Service process action team reported with the limited review we conducted.

Management Control Program

DoD Directive 5010.38, "Internal Management Control Program," April 14, 1987, requires DoD organizations to implement a comprehensive system of management controls that provides reasonable assurance that programs are operating as intended and to evaluate the adequacy of the controls.

We reviewed the Directorate of Medical Materiel management controls as they related to the obligation and billing for prime vendor purchases, vendor pricing, and the controls over the automated programs used by MTFs to identify covered items and medically equivalent substitute items. Generally, management controls for prime vendor related transactions were adequate in that we identified no material management control weaknesses.

Prior Audits and Other Reviews

During the last 5 years, two audit reports addressed the DoD Prime Vendor Program. Enclosure 3 discusses the two audit reports.

Background

In 1992, the Defense Logistics Agency developed major procurement initiatives to improve readiness and to accomplish major savings for customers. One initiative was to "Buy Response Not Inventory." That initiative was designed to use industry's production capability and commercial distribution systems to satisfy customer requirements instead of buying stock and holding it in inventory. The Prime Vendor Program for the purchase of medical supplies supports that initiative.

Prime Vendor Program. The Directorate of Medical Materiel, DPSC, developed the Prime Vendor Program for the purchase of medical supplies by using commercial business practices to support the needs of MTFs operated by DoD and other Government organizations. A prime vendor is a single distributor of various brand-name medical supplies for a group of hospitals in a geographic region. The Directorate of Medical Materiel designated 24 regions across the United States, Asia, Europe, and Panama, with each region having a separate contract for medical and surgical items and pharmaceutical items.

Prime Vendor Awards. The Directorate of Medical Materiel awarded the first pharmaceutical contract in January 1993 and the first medical and surgical contract in June 1993. Each award covered MTFs in the National Capital region (the Washington, DC area) and purchases from prime vendors began from 45 to 110 days of the award of each contract. The Department of Veteran Affairs also awarded prime vendor contracts to support its hospitals and, in one region, DoD MTFs were included in the Department of Veteran Affairs contract.

At the end of FY 1995, 6 medical and surgical contracts (covering 6 regions) and 20 pharmaceutical contracts (covering 22 regions) had been awarded. Those 26 contracts represent agreements to purchase approximately \$114 million annually in medical and surgical items and \$908 million annually in pharmaceuticals. At the end of FY 1995, 44 MTFs were covered under medical and surgical contracts and 236 MTFs were covered under pharmaceutical contracts. The number of MTFs that participate in the Prime Vendor Program increased or decreased each month because some MTFs, particularly Navy ships, do not purchase through prime vendors every month.

Discussion

Benefits of the Prime Vendor Program. Benefits of the Prime Vendor Program have been achieved, particularly for pharmaceutical items. Pharmaceutical commercial business practices were well established and standardized when DoD adopted those practices; consequently, the benefits were immediately attained by all participating MTFs.

The major benefits of the Prime Vendor Program were:

- o reduced inventory,
- o increased customer satisfaction, and
- o reduced materiel prices.

See Enclosure 1 for a detailed discussion of the major benefits achieved by the implementation of the Prime Vendor Program.

Minor Errors Identified. We identified errors in two automated programs used by MTFs, errors in the processing of prime vendor transactions, and errors in one prime vendor methodology used to determine the cost of materiels.

The following is a list of errors we identified.

- o Catalog data were incomplete and contained incorrect information.
- o One application program incorrectly computed materiel prices.
- o Requisitions were not properly valued.
- o One prime vendor did not charge the correct price.
- o MTFs did not take full advantage of manufacture rebate programs.

The discrepancies identified in the report are considered minor and actions taken to correct them were appropriate and timely. The discrepancies are included in this report, as lessons learned, because the Defense Logistics Agency plans to expand the Prime Vendor Program to other consumable items. See Enclosure 2 for a detailed discussion of the reported errors and the corrective actions taken.

Management Actions. Personnel at the Directorate of Medical Materiel; the Office of the Comptroller, DPSC; the Defense Logistics Services Center; and prime vendors corrected the deficiencies identified in this report. In addition, personnel in Directorate of Medical Materiel stated that they will discuss the discrepancies, including the correct procedures for submitting prime vendor transactions, during their annual visits to the MTF.

Management Comments

We provided a draft of this report to management on March 22, 1996. Because the report contains no findings or recommendations, written comments were not required, and none were received. Therefore we are publishing this report in final form.

We appreciate the courtesies extended to the audit staff. For additional information on this report, please contact Mr. Bernard J. Siegel, Audit Project Manager, at (215) 737-3881 (DSN 444-3881). See Enclosure 5 for the report distribution. A list of audit team members is on the inside back cover.


David K. Steensma
Deputy Assistant Inspector General
for Auditing

Enclosures

Prime Vendor Program

Background

Prime Vendor Business Practices. The DoD Prime Vendor Program mirrors, but does not completely reflect, business practices in the commercial medical treatment community. Four principal participants, with distinct responsibilities, help to ensure the successful implementation of the Prime Vendor Program. They are the Directorate of Medical Materiel, DPSC; holders of DAPAs; MTFs; and prime vendors.

Directorate of Medical Materiel. The Directorate of Medical Materiel is responsible for the overall implementation of the Prime Vendor Program. It must:

- o negotiate DAPAs (official agreements between the Directorate of Medical Materiel and manufacturers or wholesale distributors [collectively known as DAPA holders]) that include the items and the cost for items that are available for purchase from prime vendors;
- o award prime vendor contracts;
- o provide program support, guidance, and problem resolution to MTFs;
- o validate prime vendor invoices and authorize the appropriate amount for payment; and
- o bill MTFs for the total cost of prime vendor purchases.

DAPA Holders of Medical and Surgical Items and Pharmaceutical Items. DAPA holders of medical supplies identify items they are willing to supply under the Prime Vendor Program. Those items, including their cost, are identified on DAPAs. DAPA holders charge prime vendors the DAPA price for items MTFs purchased under the Prime Vendor Program. They must notify the Directorate of Medical Materiel of any price increase before charging the new price. Price changes become effective only once a month, usually 2 months after DAPA holders notify the Directorate of Medical Materiel of the change. DAPA holders can charge lower prices at any time but they must still notify the Directorate of Medical Materiel.

Medical Treatment Facilities. The MTFs are responsible for ordering covered medical, surgical, and pharmaceutical items from prime vendors. They are also responsible for:

- o identifying to the Directorate of Medical Materiel items they would like to include in the Prime Vendor Program that are not included in DAPAs;

Prime Vendor Program

- o identifying to prime vendors all medical, surgical, and pharmaceutical items covered by DAPAs (including estimated usage data) that are routinely purchased, to ensure that those items are available when they are ordered;
- o ensuring that all medical supplies are received from prime vendors in the quantity ordered, and that all adjustments to the order (item, price, quality, or quantity) are identified to the prime vendor for correction;
- o submitting a single-line summary requisition, as frequently as daily, to the Directorate of Medical Materiel that represents the total value of the materiel actually received (used by the Directorate of Medical Materiel for vendor invoice validation);
- o reimbursing the Directorate of Medical Materiel for the total amount of the prime vendor purchases; and
- o identifying any program deficiencies or needed enhancements to the Directorate of Medical Materiel or the prime vendor.

Prime Vendors. Prime vendors receive MTF orders and fill them from their inventory within 24 hours of receipt. Additionally, prime vendors must:

- o notify the MTF when an ordered item is not available or not authorized for purchase;
- o resolve product deficiencies or shipping discrepancies (item, price, quality, or quantity) that the MTF identifies; and
- o submit invoices to the Directorate of Medical Materiel that reflect the total value (materiel cost and prime vendor distribution fee) of the materiel shipped to and accepted by the MTF.

Benefits Achieved

The major benefits of the Prime Vendor Program were:

- o reduced inventory in DoD wholesale storage depots and MTFs;
- o increased customer satisfaction, including electronic payment of invoices; and
- o reduced prices on wholesale and retail items.

Reduced Inventory. Defense Logistics Agency wholesale medical inventories and MTF retail medical inventories have decreased since the medical prime vendor program began in 1993. Those reductions are attributed to the ability of MTFs to order smaller quantities, more frequently, because prime vendors can deliver medical supplies from available prime vendor stock within 24 hours (emergency deliveries within 6 hours). In addition, losses created by the expiration and overstocking of pharmaceuticals have also been reduced.

Customers at MTFs we visited and respondents to a customer survey on the Prime Vendor Program also stated that they were using less storage space. However, the MTFs did not quantify the amount of warehouse space that was reduced. In many instances, customer conclusions were based on known inventory and stock level reductions and on observations of existing storage space.

Wholesale Storage Depot Inventory. Defense Logistics Agency wholesale medical inventories have decreased as the result of various inventory reduction initiatives, including the Prime Vendor Program. In January 1992, medical inventories at DoD storage depots totaled \$607 million--361 million in medical and surgical items and \$246 million in pharmaceutical items. By March 1993, those inventories had been reduced as the result of humanitarian assistance, disposal actions, and other inventory reduction initiatives. After March 1993, wholesale medical inventories continued to decline, principally as the result of the Prime Vendor Program. As shown in Figure 1, wholesale medical inventories have decreased from \$333 million in March 1993 to \$206 million in September 1995. The largest decrease was for pharmaceutical items--from \$140 million to \$49 million.

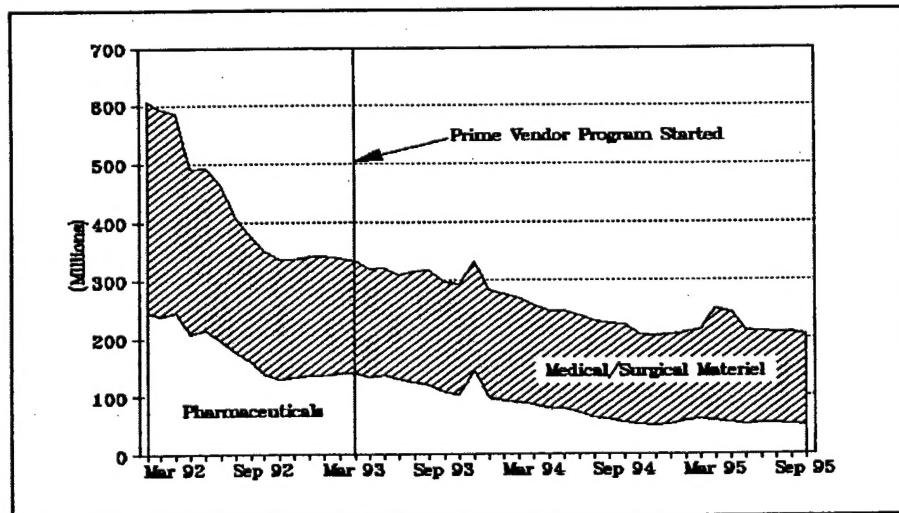


Figure 1. Value of Medical Inventory in DoD Wholesale Depots

Prime Vendor Program

Retail Inventory. The benefit of reductions in retail inventory was also achieved at the 12 MTFs we visited. Personnel at those 12 MTFs indicated that retail inventories decreased usually after the facility had participated in the Prime Vendor Program and had gained sufficient confidence in the program--generally within the first year. In addition, the responses to a customer survey from 116 respondents showed that similar benefits were achieved. Of the 116 respondents, 101 answered the question on inventory stock levels at retail facilities. Forty indicated that inventory levels were set at a maximum of 7 days, 46 set inventory levels at between 7 and 30 days, and 15 set levels at 30 to 60 days of demand. Historically, maximum inventory levels ranged from 90 to 180 days of demand. We did not validate those responses.

Customer Satisfaction. Customers (including the 12 MTFs we visited and respondents to the customer survey) stated that they were very satisfied with the Prime Vendor Program and that most of the desired benefits have been achieved, particularly in the area of pharmaceuticals. They further stated that prime vendors maintain a broader range of items that can be delivered within 24 hours, at reduced materiel costs. Payment of vendor invoices has been streamlined and most processes are performed electronically. Prime vendors submit invoices electronically, payment is authorized and disbursed electronically (usually through electronic funds transfer), and the Directorate of Medical Materiel bills MTFs through established interfund billing procedures.

Another indication of customer satisfaction with the Prime Vendor Program can be illustrated by the steady increase in purchases since the beginning of the Prime Vendor Program. During the last 6 months of FY 1993, purchases from prime vendors totaled \$10 million. Purchases increased to \$170 million in FY 1994 and \$476 million in FY 1995. Figure 2 shows the purchases by month and by fiscal year since March 1993.

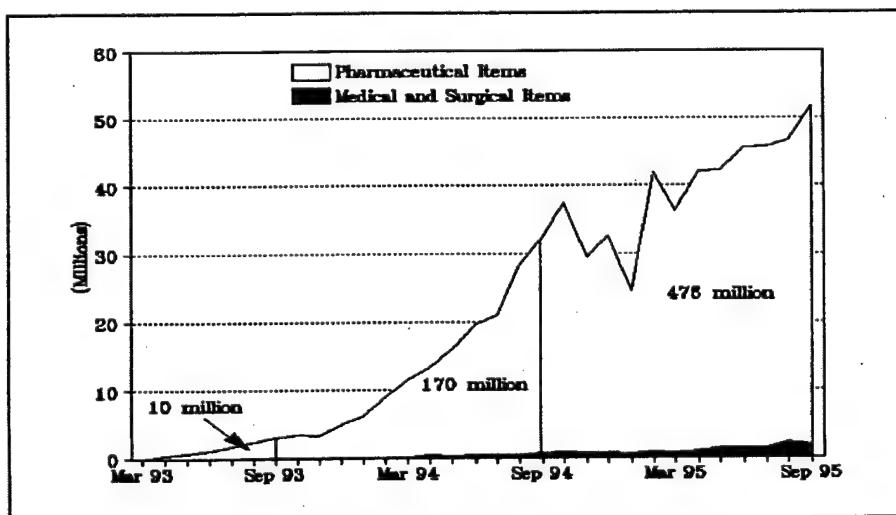


Figure 2. Customer Purchases From Prime Vendors

The increase in purchases can be attributed to:

- o an increase in the number of prime vendor contract awards (from 6 at the end of FY 1993 to 26 at the end of FY 1995),
- o an increase in the number of MTFs participating in the Prime Vendor Program (from 11 in January 1993 [pharmaceutical items] to 44 purchasing medical and surgical items and 236 purchasing pharmaceutical items in September 1995),
- o an increase in the number of medical items that are available for purchase through the prime vendor, and
- o a decrease in retail inventories that were previously purchased either locally or through the DoD central supply system.

Reduced Materiel Prices. Another achieved benefit of the Prime Vendor Program was that materiel costs for items purchased through the Prime Vendor Program were generally less than the same item purchased through the DoD central supply system. Medical supplies purchased from the DoD central supply system included a surcharge of 20 percent. Materiel purchased under the Prime Vendor Program included a surcharge of from 4.5 percent to 7.5 percent for medical and surgical items and from 0.25 percent to 1.9 percent for pharmaceutical items. The surcharge includes the 1 percent DPSC service fee and the prime vendor distribution fee that is different for each contract.

Lessons Learned

Introduction

The Directorate of Medical Materiel has successfully implemented a "Buy Response Not Inventory" procurement process that mirrors commercial business practices for the purchase of medical supplies. The success of that program will be used to develop similar commercial practices for other consumable items purchased by Defense Logistics Agency supply centers, including hardware and personnel support items. The lessons learned in developing the medical Prime Vendor Program will help in the implementation of other non-medical commercial business practices. The following discussion highlights minor errors we identified during our review. They should be considered when implementing similar procurement programs.

Minor Errors Identified

We identified errors in the PPC and MEDCAT-X automated programs used by MTFs, errors in valuation of prime vendor transactions, and errors in one prime vendor methodology used to determine the costs of materials. We also noted that MTFs were not taking full advantage of manufacturer rebate programs. Unless otherwise noted, appropriate action was taken to correct the identified errors. The following is a list of errors we identified and a discussion of each.

- o Catalog data selected for analysis of pricing from the PPC and MEDCAT-X were incomplete and contained incorrect units of measure.
- o The MEDCAT-X automated application program used the incorrect distribution fee for one region and incorrectly computed the detail pricing for all regions.
- o The value of requisitions that MTFs submitted did not always represent the actual value of materiel received from the prime vendor (MTFs used three different methods to value prime vendor purchases).
- o One prime vendor did not charge one MTF the correct price for materiel purchased under the prime vendor program.
- o MTFs did not always take advantage of manufacturer rebate programs and could not identify the number and value of those programs in which they participated.

Automated Programs

Two automated programs, PPC and MEDCAT-X, were provided to MTFs to assist in the identification of available medical items and to identify medically equivalent or substitute items. Those programs also included pricing information that could be used to make appropriate purchasing decisions. However, catalog data contained in the two automated programs used in our analysis of pricing were incomplete and contained incorrect units of measure. In addition, one of the automated application programs used the incorrect distribution fee for one region and incorrectly computed the detail pricing for all regions. Finally, the region number between the two applications was inconsistently assigned.

Use of Catalog Data. Catalog data contained in the two automated programs did not always provide complete or accurate information to the user. Those automated programs were used in researching the availability of medical supplies and related substitute items from prime vendors. The prices shown in the programs represented the last approved price change at the time the program was distributed to users; but the actual prices paid may have been either higher or lower.

PPC Program. Electronic Data Systems (a contractor) developed the PPC program as part of its design of the standard medical logistics system, the Defense Medical Logistics Standard Support. Electronic Data Systems continuously revised and improved the disk-based computer application based on comments it received from the Directorate of Medical Materiel, MTFs, and other Service associated medical logistics organizations. The August 1995 version of the program contained over 175,000 medical and surgical and pharmaceutical items available from prime vendors and wholesale storage depots. The 1995 program was an improvement over previous versions, but discrepancies still existed.

The discrepancies generally included pricing for items that have general units of measure (for example, case or package) instead of specific quantities in the saleable unit. Because the unit of measure quantity either was not included in the item description or was incorrect, the unit of measure cost was not correct and personnel at the MTF could not make a proper comparison. Electronic Data Systems and the Directorate of Medical Materiel were resolving those discrepancies with manufacturers.

Use of MEDCAT-X Program. Pricing data contained in the MEDCAT-X program did not always provide accurate pricing information to the user. The MEDCAT-X is an expanded catalog of medical and surgical and pharmaceutical items incorporating information from DAPAs; the Federal Logistics Information System; and two commercial data bases, the Common Category Database and the National Drug Description File. The MEDCAT-X program contained all information that was available on the PPC (including incorrect units of measure) but included expanded item characteristics and integrated commercial data with Federal logistics data (including Service-unique logistics data).

We identified differences between the MEDCAT-X prices and the prices prime vendors charged. Those prices also differed from the prices in the PPC program and the hard copy of DAPAs. We showed personnel at the Defense Logistics Services Center, Battle Creek, Michigan, the price differences and requested that they validate our finding and take corrective action. The Defense Logistics Services Center took action to correct the error in the MEDCAT-X in November 1995. We attributed the differences in price to two errors in the MEDCAT-X program, the distribution fee and detail pricing.

MEDCAT-X Distribution Fee. The distribution fee for the Grand Ole Opry region was incorrectly identified as 99.89 percent of the materiel cost identified in the DAPAs. However, the actual distribution fee was -0.11 percent. For example, an item with a DAPA cost of \$100 had a prime vendor distribution fee of \$99.89 and a DPSC service fee (1 percent) of \$2, a total price of \$201.89. The correct costs should have been \$100 (DAPA cost), less \$0.11 (distribution fee), plus \$1 (DPSC service fee)--for a total price of \$100.89 (a difference of \$101). As a result, the price reflected in the MEDCAT-X application was about twice the actual cost and could mislead personnel at MTFs.

Some DAPA holders charge prime vendors prices that are less than the prices DAPA holders negotiated with the Directorate of Medical Materiel. Because competition for prime vendor contracts is so intense, prime vendors are willing to pass some of those savings to MTFs through a negative distribution fee in order to obtain the award for selected geographic regions.

MEDCAT-X Detail Pricing. Detail level pricing provided in the MEDCAT-X program was not always accurate. The MEDCAT-X program included a summary level display and a detail level display. With the exception of the Grand Ole Opry region noted above, the cost for each item displayed in the summary level was correct. However, the MEDCAT-X program incorrectly applied the prime vendor distribution fee and the DPSC service fee to the DAPA cost twice, overstating the total cost of the item.

Use of Region Numbers. The region number used to identify the appropriate distribution fee to add to the basic DAPA price was different in the PPC and the MEDCAT-X programs. Only five regions were identified by the same region number in both programs. The remaining 19 regions were identified by different region numbers. For example, the San Francisco region was identified as region 3 in the PPC program and region 5 in the MEDCAT-X program. The MTFs often used both programs and each should have referenced common fields consistently to avoid confusion and misuse of the programs. Personnel in the Directorate of Medical Materiel stated that those differences between the two programs will be corrected in the standard medical logistics program. A part of the program is currently being tested and is scheduled for full implementation in FY 2001.

Lessons Learned

Minor Pricing Differences. Materiel prices that prime vendors charged were different than the authorized prices included in DAPAs. We judgmentally selected for review 48 prime vendor invoices that included 4,118 items, totaling \$1.4 million, from the 12 MTFs we visited. Those invoices were issued from March through June 1995. To determine the validity of the prices that prime vendors charged, we compared the invoice price with the authorized prices contained in the May 23, 1995, version of the PPC program that the Directorate of Medical Materiel provided and the August 1995 version of the MEDCAT-X program obtained from the Defense Logistics Services Center. The prices in those programs should reflect the current authorized DAPA price. When either the invoice price was significantly different (greater than 5 percent) or the selected item was not contained in the MEDCAT-X and PPC, we compared the invoice price to the hard copy of the DAPA.

The invoice price agreed with the authorized price for 2,894 of the 4,118 items we reviewed. For 616 of the remaining 1,224 items, the invoice price was greater than the authorized price by \$4,664; for 571 of the 1,224 items, the invoice price was less than the authorized price by \$7,586. Consequently, MTFs paid \$2,922 less than the authorized price for purchases totaling \$506,974. We considered those differences to be minor and not significant enough to warrant corrective action at this time.

We were unable to determine whether the invoice price was correct for the remaining 37 of 1,224 items because the Directorate of Medical Materiel had no documentation, hard copy or automated, to show that the items were covered on a DAPA and to show whether the price was appropriate.

Errors in Transaction Processing

We identified errors in establishing vendor obligations, and prime vendor charges; however, those discrepancies were minimal. We informed personnel in the Directorate of Medical Materiel; Office of the Comptroller, DPSC; and prime vendors of the errors. Appropriate action was taken to correct the identified errors discussed below.

The value of requisitions that MTFs submitted did not always represent the actual value of materiel received (including surcharges) from the prime vendor. MTFs did not always exclude the value of the materiel that was ordered and confirmed for shipment by the prime vendor but was either not received or was later returned to the prime vendor. Additionally, one prime vendor, FoxMeyer, Dallas, Texas, did not include all materiel and surcharge costs for purchases by one MTF. Consequently, the obligated value of summary requisitions used to determine the amount to pay FoxMeyer was not correct.

Establishing Vendor Obligations. We reviewed the procedures at the 12 MTFs and summarized the responses to a customer survey from 116 requisitioners to determine how MTFs value requisitions for prime vendor purchases. Customers used three different methods to value prime vendor purchases.

- o Method 1 - the value of all materiel received for each order, less the value of materiel received and returned to the prime vendor.
- o Method 2 - the value of all materiel ordered for each requisition, whether the materiel was received or received and later returned to the prime vendor.
- o Method 3 - the value of all materiel ordered for each requisition less any credit vouchers received from the prime vendor for shortages attributed to prior orders.

In a customer survey, we asked ordering points to identify the method used to value each prime vendor summary requisition submitted to the Directorate of Medical Materiel. Of the 116 requisitioners that responded to that question, 101 stated that they used method 1. The remaining 15 ordering points used either method 2 or method 3.

The Directorate of Medical Materiel stated that only method 1 is correct because they need the value of the requisition to contractually obligate funds for each prime vendor purchase. That amount was the maximum amount that the Defense Finance and Accounting Service was authorized to pay the prime vendor. When MTFs use method 2, the value of the requisition included the materiel that was not received. Consequently, the obligated amount was overstated and that could lead to an overpayment to the prime vendor.

When MTFs use method 3 to value requisitions, the obligated amount for the current requisition will be less than the invoice amount and only the obligated amount will be paid to the prime vendor. When MTFs use method 3 to value requisitions, the obligated amount will be less than the invoice amount and only the obligated amount will be paid to the prime vendor. Consequently, depending on the value of the discrepancy, prime vendors would ask the Directorate of Medical Materiel to research the underpayment and make appropriate adjustments to the invoice payment.

The requirement to only use method 1 was included in a Prime Vendor Program desk reference that the Directorate of Medical Materiel provided to all participating MTFs. Personnel in the Directorate of Medical Materiel have agreed to include that requirement in prime vendor newsletters and will reiterate the requirement during interim progress reviews at the MTFs.

Lessons Learned

Prime Vendor Charges. One prime vendor, FoxMeyer, did not include all materiel costs for purchases by Munson Army Community Hospital, Fort Leavenworth, Kansas. As a result, the value of requisitions that the MTF submitted to the Directorate of Medical Materiel were understated. We estimated that the prime vendor undercharged Fort Leavenworth \$20,538 from November 1994 through September 1995.

The prime vendor advised us that the Kansas City office corrected its method for computing the invoice price for pharmaceutical items purchased by Fort Leavenworth. FoxMeyer also stated that it will not seek reimbursement for past undercharges.

Manufacturer Rebates

We conducted a limited review of the MTFs use of manufacturer rebates. Limited information on the scope of the rebate program was available from either MTFs or the Directorate of Medical Materiel. Manufacturers provide rebates based on the volume of purchases an MTF makes for a specific pharmaceutical item during a specific period. Prime vendors provide manufacturers with MTF usage information that is used to compute authorized rebate amounts. The rebate amount is computed as either a percentage of total sales for that item or a percentage of sales in excess of a stated baseline for that item. Rebate programs can provide significant benefit to MTFs but information relating to those programs is limited.

Facilities That Received Rebates. The Prime Vendor Program did not contain procedures to identify manufacturer rebate programs to MTFs. The Directorate of Medical Materiel and prime vendors could not identify the total amount of manufacturer rebates that MTFs earned, whether those rebates were used, and how many rebates remained unused. Additionally, MTFs had difficulty identifying the number and dollar amount of rebates earned.

For the 12 MTFs we visited, only 6 had received rebates. Those six MTFs used rebates to purchase pharmaceutical items either directly from the manufacturer or from the prime vendor at no cost. The pharmaceutical items included either the same item for which the rebate was earned or other qualified items. Purchases made with manufacturer rebates were not recorded in the procurement system. In all instances, the materiel was placed in inventory and issued under the same procedures as materiel that had been purchased through the procurement system.

Rebate Information in Customer Survey. Most respondents to the customer survey did not identify any rebates. We could not determine whether the MTFs did not receive any rebates or whether our question concerning rebates was misinterpreted. During our discussion with personnel at the 12 MTFs we visited, we learned that the terms credit, rebate, and refund were often used interchangeably. MTFs sometimes considered rebates as "cash" payments received from manufacturers. Our review showed no instances in which cash was given to MTFs under the Prime Vendor Program.

Tri-Service Process Action Team. A Tri-Service process action team of the Joint Medical Logistics Functional Development Center, under the authority of the Assistant Secretary of Defense (Health Affairs) was formed in early FY 1995 to analyze the rebate process, determine alternatives to the rebate process, and make recommendations that would allow the Services to effectively use the revenues available from credits, rebates, and refunds.

The Tri-Service team recommended that members of the Medical Logistics Property Subcommittee:

- o standardize the definitions of credits, rebates, and refunds and encourage all MTFs to use them.
- o survey all manufacturers, prime vendors, and DAPA holders to determine the availability of rebate programs and provide them with general guidelines for operating a rebate program. In addition, the availability of rebates should be used by the Tri-Service Formulary/Preferred Drug List, in awarding best value contracts.

In addition to the above recommendations, the Tri-Service team recommended that developers of the Defense Medical Logistics Supply System address the use of rebates, including the procedure for processing them.

Summary of Prior Audits

During the last 5 years, two audit reports addressed the DoD Prime Vendor Program. They are summarized below.

General Accounting Office. General Accounting Office Report No. NSIAD 95-142 (OSD Case No. 9919), "Inventory Management: DoD Can Build on Progress in Using Best Practices to Achieve Substantial Savings," August 4, 1995, reported that the Prime Vendor Program for medical supplies is the most successful program in DoD. However, DoD MTFs have not achieved the same level of inventory reductions as civilian hospitals. The General Accounting Office recommended that DoD use the Prime Vendor Program in enhancing the partnership between DoD MTFs and the prime vendor. DoD generally agreed with the findings, conclusions, and recommendations and stated that additional steps are underway in adopting best commercial practices in both personal and hardware items.

Air Force Audit Agency. Air Force Audit Agency Report No. 94051011, "Review of the Medical Prime Vendor Contracting Program," October 31, 1995, reported that the Air Force implemented the medical Prime Vendor Program in a generally effective manner. However, MTFs could realize further inventory reductions in both medical supply warehouses and pharmacies. The Air Force Audit Agency recommended that the Surgeon General of the Air Force establish a policy that requires MTFs to minimize investment in inventory and require specific justification for maintaining warehouse inventory for pharmaceutical items purchased from the prime vendor. Additionally, it recommended that pharmacies reduce their stockage objectives for prime vendor items to 5 days. Management generally agreed with the findings, conclusions, and recommendations and stated that it would eliminate or minimize all pharmaceutical products in the warehouse and minimize pharmacy inventory for items that are procured from the prime vendor; however, the final decision should remain with the local activity.

Organizations Visited or Contacted

Office of the Secretary of Defense

Assistant Secretary of Defense (Health Affairs), Washington, DC
Joint Medical Logistics Functional Development Center, Fort Detrick, Frederick, MD

Department of the Army

Office of the Surgeon General, Washington, DC
U.S. Army Medical Command, San Antonio, TX
Evans Army Community Hospital, Fort Carson, CO
Keller Army Community Hospital, West Point, NY
Munson Army Community Hospital, Fort Leavenworth, KS
Walter Reed Army Medical Center, Washington, DC
Womack Army Medical Center, Fort Bragg, NC

Department of the Navy

Bureau of Medicine and Surgery, Washington, DC
Naval Hospital, Camp Lejeune, NC
Naval Hospital, Jacksonville, FL
Naval Hospital, Millington, TN
Naval Hospital, Portsmouth, VA

Department of the Air Force

Air Force Medical Support Activity, San Antonio, TX
5th Medical Group, Minot Air Force Base, ND
366th Medical Group, Mountain Home Air Force Base, ID
436th Medical Group, Dover Air Force Base, DE
Malcolm Grow US Air Force Medical Center, Andrews Air Force Base, MD

Other Defense Organizations

Headquarters, Defense Logistics Agency, Alexandria, VA
Defense Personnel Support Center, Philadelphia, PA
Defense Logistics Service Center, Battle Creek, MI

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5th Medical Group
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Malcolm Grow US Air Force Medical Center

Defense Organizations

Director, Defense Contract Audit Agency
Director, Defense Logistics Agency
Commander, Defense Personnel Support Center
Director, National Security Agency
Inspector General, National Security Agency

Non-Defense Federal Organizations and Individuals

Office of Management and Budget
General Accounting Office
 National Security and International Affairs Division
 Technical Information Center
Chairman and ranking minority member of each of the following congressional committees and subcommittees
 Senate Committee on Appropriations
 Senate Subcommittee on Defense, Committee on Appropriations
 Senate Committee on Armed Services
 Senate Committee on Governmental Affairs
 House Committee on Appropriations
 House Subcommittee on National Security, Committee on Appropriations
 House Committee on Government Reform and Oversight
 House Subcommittee on National Security, International Affairs, and Criminal Justice, Committee on Government Reform and Oversight
 House Committee on National Security

Audit Team Members

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